Headquarters U.S. Air Force

Integrity - Service - Excellence

AHLTA & Data Entry
A Provider's Perspective

Data Quality Manager's Course
September 2012

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AHLTA & Data Entry
A Provider's Perspective

Objectives

- **A review of how an average provider views coded data and metrics**
- **Demonstrate issues regarding data entry into our outpatient systems**
  - **Clinical-centric data**
  - **Business-centric data**
- **Understand difference between "documentation" and "coding" to see why some data errors may arise**

Observation #1

Metrics Drive Behavior

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Metrics in Action

- **Commander: “I want my facility to get as many Relative Value Units (RVUs) as we should to reflect the hard work we are doing”**
- **Business Office: “Facility RVUs is a product of number of encounters times the RVUs/encounter. We should increase the RVUs/encounter to increase facility RVUs”**
- **Clinic Chief: “We have a lot of t-cons that are worth very few RVUs, and that brings our RVU/encounter down. So admin-out all of the t-cons so that our RVU/encounter goes up”**

This occurred at a facility I visited. The focus in a clinic on a single metric (RVU/Encounter) drove a behavior that the Commander *never* meant to have happen!

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Common Provider Metrics

- **Empanelment**
- **Number of patients seen each day/week/month**
- **Number of no-shows**
- **Patient Satisfaction**
- **HEDIS compliance**
- **RVUs/visit**
- **RVUs/day**

As a “lowly” provider, there are relatively few that I can directly impact.

CLINICAL DATA

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Clinical Data - Outpatient

In the outpatient realm, clinical data can be separated into a few broad categories:

- **Data from AHLTA**
  - **Information in the S/O module (subjective/objective data)**
  - **ADM data from the A/P and disposition modules (diagnoses, procedure codes, orders)**
- **Data from CHCS**
  - **Orders & results data**
  - **Billing data**
  - **Appointment data**
- **Data from other systems (Service readiness systems, etc)**
- **Outside data (E.g. claims data in M2)**

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Clinical Data – AHLTA

- **We are seeing wide-scale adoption of the Tri-Service Workflow AIM form**
- **Lots of discrete elements are now being captured routinely in the S/O module of AHLTA**
- **No system mechanism available to “mandate” any usage of the S/O module**

Clinical Data – Outpatient

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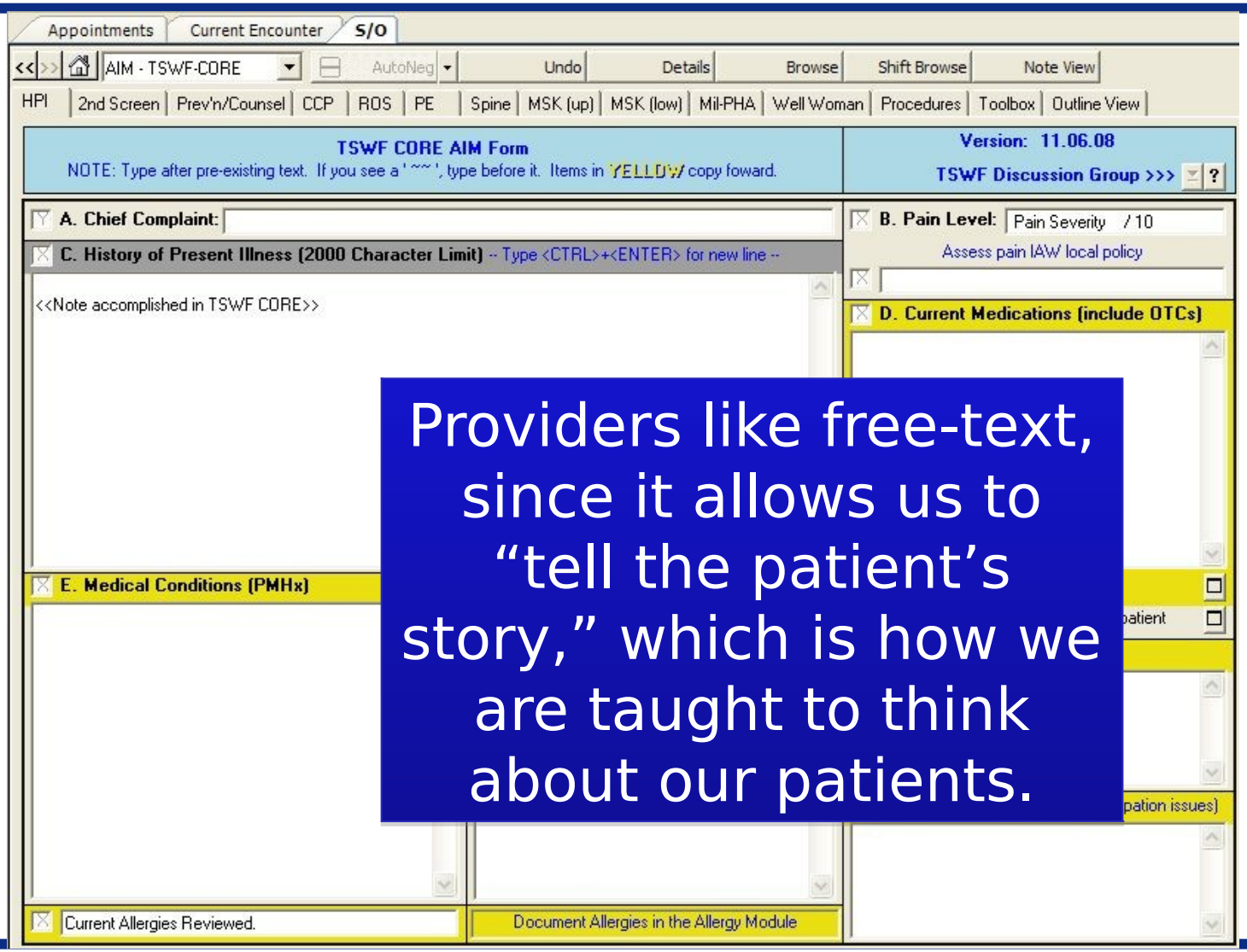

Providers like free-text, since it allows us to "tell the patient's story," which is how we are taught to think about our patients.

Clinical Data - AHLTA

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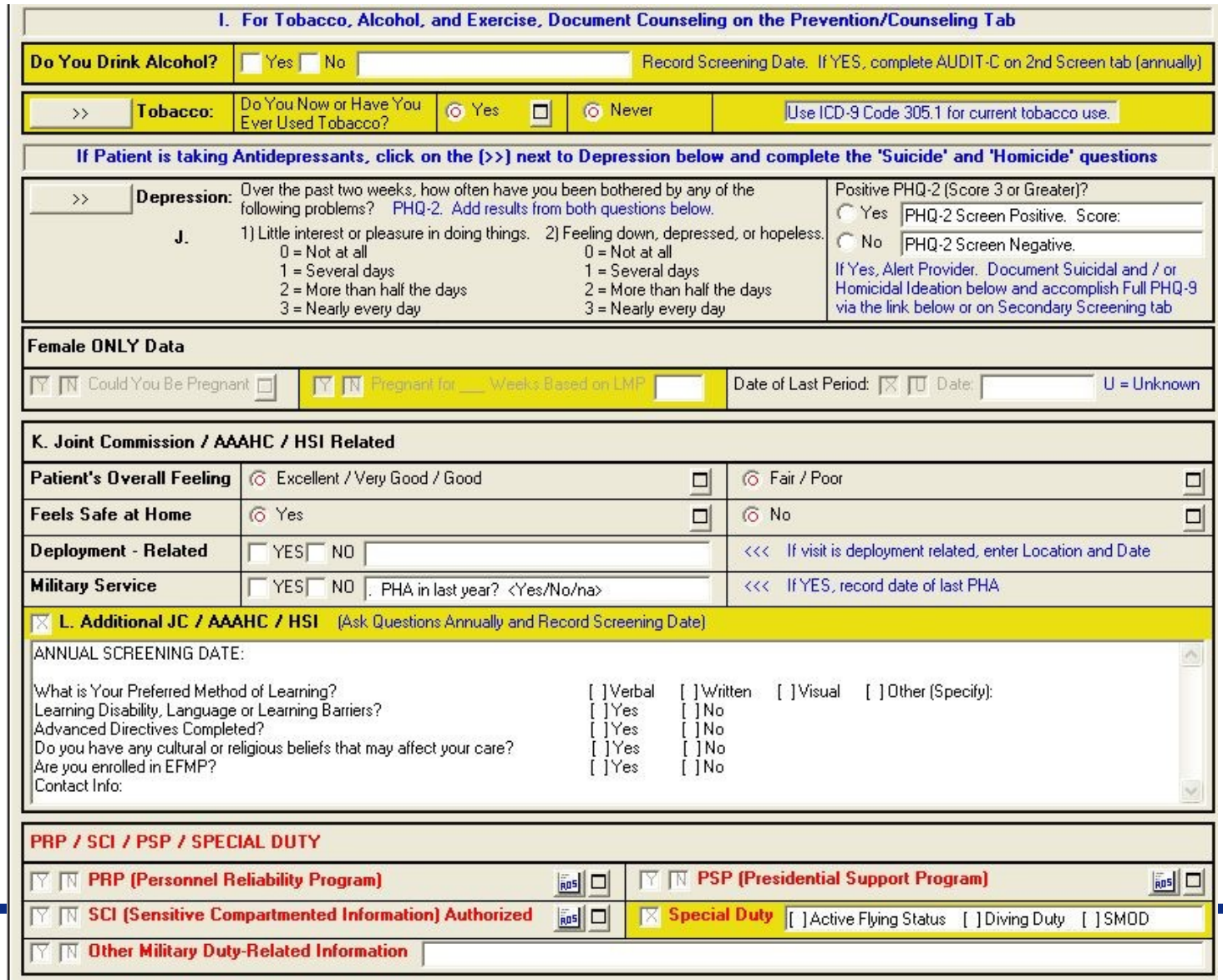


I. For Tobacco, Alcohol, and Exercise, Document Counseling on the Prevention/Counseling Tab

Do You Drink Alcohol? ☐ Yes ☐ No — Record Screening Date. If YES, complete AUDIT-C on 2nd Screen tab (annually)

>> Tobacco: Do You Now or Have You Ever Used Tobacco? ◎ Yes ☐ ◎ Never — Use ICD-9 Code 305.1 for current tobacco use.

If Patient is taking Antidepressants, click on the (>>) next to Depression below and complete the 'Suicide' and 'Homicide' questions

>> Depression: Over the past two weeks, how often have you been bothered by any of the following problems? PHQ-2. Add results from both questions below.

J. 1) Little interest or pleasure in doing things. 2) Feeling down, depressed, or hopeless.
0 = Not at all
1 = Several days
2 = More than half the days
3 = Nearly every day

Positive PHQ-2 (Score 3 or Greater)?
◎ Yes PHQ-2 Screen Positive. Score:
◎ No PHQ-2 Screen Negative.
If Yes, Alert Provider. Document Suicidal and / or Homicidal Ideation below and accomplish Full PHQ-9 via the link below or on Secondary Screening tab

Female ONLY Data

☐Y ☐N Could You Be Pregnant ☐ — ☐Y ☐N Pregnant for ___ Weeks Based on LMP — Date of Last Period: ☐X ☐U Date: U = Unknown

K. Joint Commission / AAAHC / HSI Related

Patient's Overall Feeling	◎ Excellent / Very Good / Good ☐	◎ Fair / Poor ☐
Feels Safe at Home	◎ Yes ☐	◎ No ☐
Deployment - Related	☐ YES ☐ NO	<<< If visit is deployment related, enter Location and Date
Military Service	☐ YES ☐ NO . PHA in last year? <Yes/No/na>	<<< If YES, record date of last PHA

☒ L. Additional JC / AAAHC / HSI (Ask Questions Annually and Record Screening Date)

ANNUAL SCREENING DATE:

What is Your Preferred Method of Learning?	[ ]Verbal	[ ]Written	[ ]Visual	[ ]Other (Specify):
Learning Disability, Language or Learning Barriers?	[ ]Yes	[ ]No		
Advanced Directives Completed?	[ ]Yes	[ ]No		
Do you have any cultural or religious beliefs that may affect your care?	[ ]Yes	[ ]No		
Are you enrolled in EFMP?	[ ]Yes	[ ]No		

Contact Info:

PRP / SCI / PSP / SPECIAL DUTY

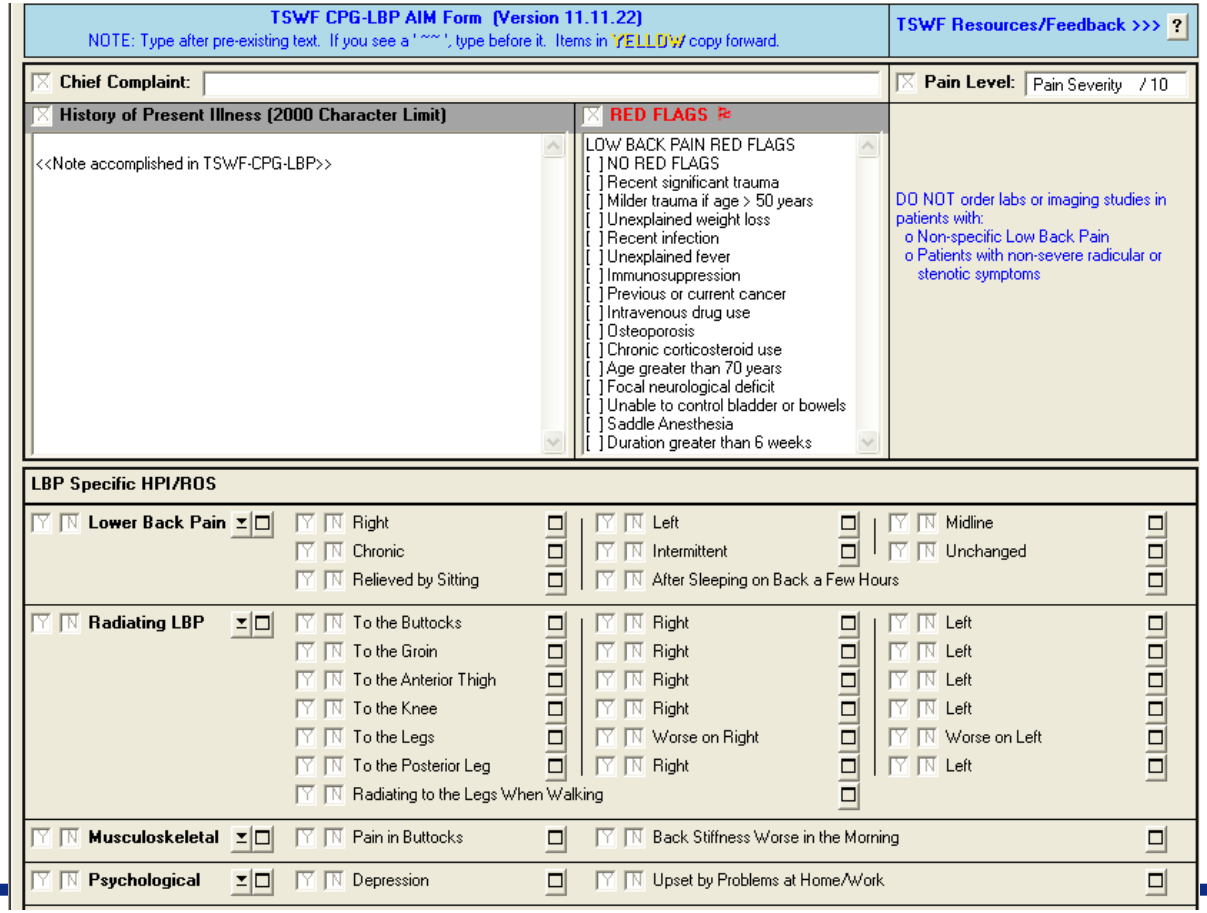
☐Y ☐N PRP (Personnel Reliability Program) ☐ — ☐Y ☐N PSP (Presidential Support Program) ☐

☐Y ☐N SCI (Sensitive Compartmented Information) Authorized ☐ — ☒ Special Duty [ ]Active Flying Status [ ]Diving Duty [ ]SMOD

☐Y ☐N Other Military Duty-Related Information

Clinical Data - AHLTA

- **We are now starting to use targeted AIM forms for specific Clinical Practice Guidelines**



TSWF CPG-LBP AIM Form (Version 11.11.22)
NOTE: Type after pre-existing text. If you see a '~~', type before it. Items in YELLOW copy forward.

TSWF Resources/Feedback >>> ?

Chief Complaint:

Pain Level: Pain Severity / 10

History of Present Illness (2000 Character Limit)

<<Note accomplished in TSWF-CPG-LBP>>

RED FLAGS

LOW BACK PAIN RED FLAGS
[ ] NO RED FLAGS
[ ] Recent significant trauma
[ ] Milder trauma if age > 50 years
[ ] Unexplained weight loss
[ ] Recent infection
[ ] Unexplained fever
[ ] Immunosuppression
[ ] Previous or current cancer
[ ] Intravenous drug use
[ ] Osteoporosis
[ ] Chronic corticosteroid use
[ ] Age greater than 70 years
[ ] Focal neurological deficit
[ ] Unable to control bladder or bowels
[ ] Saddle Anesthesia
[ ] Duration greater than 6 weeks

DO NOT order labs or imaging studies in patients with:
- o Non-specific Low Back Pain
- o Patients with non-severe radicular or stenotic symptoms

LBP Specific HPI/ROS

Lower Back Pain	Right	Left	Midline
	Chronic	Intermittent	Unchanged
	Relieved by Sitting	After Sleeping on Back a Few Hours	
Radiating LBP	To the Buttocks	Right	Left
	To the Groin	Right	Left
	To the Anterior Thigh	Right	Left
	To the Knee	Right	Left
	To the Legs	Worse on Right	Worse on Left
	To the Posterior Leg	Right	Left
	Radiating to the Legs When Walking		
Musculoskeletal	Pain in Buttocks	Back Stiffness Worse in the Morning	
Psychological	Depression	Upset by Problems at Home/Work	

Clinical Data - AHLTA

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Placing clinical

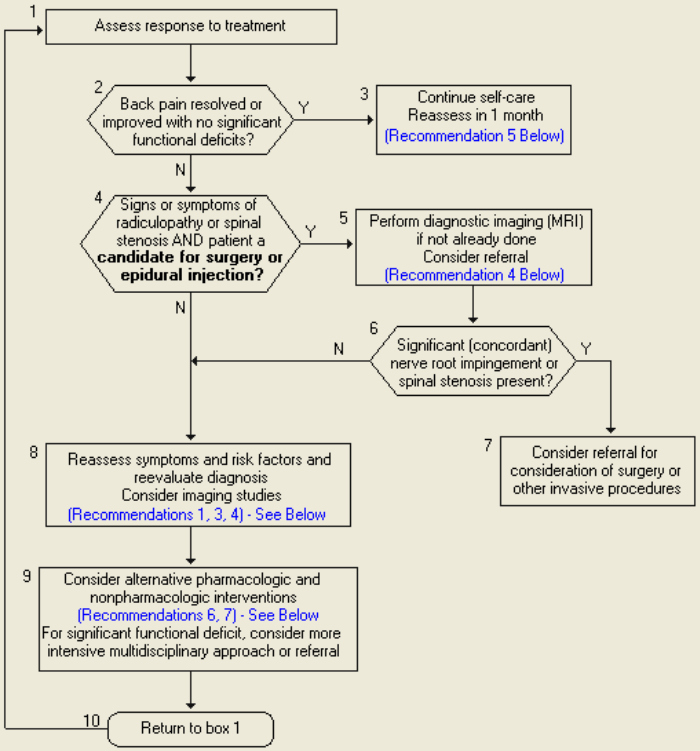
decision support

at

the point of care

HPI/ROS | PE | CCP | Initial Eval/Mgmt | F/U Mgmt | Toolbox | Outline View

Follow-Up Management of Non-specific Low Back Pain or Non-severe Radicular or Stenotic Symptoms



Interventions (Recommendations 5, 6, 7) - See Below

	Low Back Pain Duration	Acute < 4 Weeks	Subacute or Chronic > 4 Weeks
Self Care	Advice to remain active	*	*
	Books, handout	*	*
	Application of superficial heat	*	
Pharmacologic Therapy	Acetaminophen	*	*
	NSAIDS	*	*
	Skeletal muscle relaxants	*	
	Antidepressants (TCA)		*
	Benzodiazepines	*	*
	Tramadol, opioids	*	*
Nonpharmacologic Therapy	Spinal manipulation	*	*
	Exercise therapy		*
	Message		*
	Acupuncture		*
	Yoga		*
	Cognitive-behavioral therapy		*
	Progressive relaxation		*
	Intensive interdisciplinary rehab		*

* Interventions supported by grade B evidence (at least fair-quality evidence of moderate benefit, or small benefit but no significant harms, costs, or burdens). No intervention was supported by grade A evidence (good-quality evidence of substantial benefit).

CPG Recommendations

Recommendation 1: Clinicians should conduct a focused history and physical examination to help place patients with low back pain into 1 of 3 broad categories: nonspecific low back pain, back pain potentially associated with radiculopathy or spinal stenosis, or back pain potentially associated with another specific spinal cause. The history should include assessment of psychosocial risk factors, which predict risk for chronic disabling back pain (strong recommendation, moderate-quality evidence).

Recommendation 2: Clinicians should not routinely obtain imaging or other diagnostic tests in patients with nonspecific low back pain (strong recommendation, moderate-quality evidence).

Recommendation 3: Clinicians should perform diagnostic imaging and testing for patients with low back pain when severe or progressive neurologic deficits are present or when serious underlying conditions are suspected on the basis of history and physical examination (strong recommendation, moderate-quality evidence).

Recommendation 4: Clinicians should evaluate patients with persistent low back pain and signs or symptoms of radiculopathy or spinal stenosis with magnetic resonance imaging (preferred) or computed tomography only if they are potential candidates for surgery or epidural steroid injection (for suspected radiculopathy) (strong recommendation, moderate-quality evidence).

Recommendation 5: Clinicians should provide patients with evidence- based information on low back pain with regard to their expected course, advise patients to remain active, and provide information about effective self-care options (strong recommendation, moderate-quality evidence).

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Clinical Data - AHLTA

- **Having the data collected and stored discreetly invites research to be done on it. . .**

  but it's not necessarily easy to do.

- **There is no easy way to look at the data (yet)**
  - **The Air Force CarePoint project will provide access to a lot of the AHLTA-only clinical data**
  - **Should be available in about a year**
- **My office worked to get a peer-review program set up to collect data on usage of the AIM form**
  - **Peer-review data is "medical and/or quality assurance review data" and is non-discoverable. . .**
  - **. . . so it can't be used in research!**

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Observation #2

Providers care considerably more about the

quality of their documentation than they do

about the codes generated

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Clinical Data

- **Are diagnoses (i.e. the ICD-9 codes) in AHLTA clinical data or business data?**
- **Is there a difference?**
- **Is there a 1:1 correspondence between diagnoses in a paper chart and diagnoses in AHLTA?**

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Clinical Data

Diagnoses in the paper world

- **Providers could list diagnoses in any order**
- **They could call a diagnosis whatever they wanted to**
- **Coders never told a provider their diagnosis was "wrong"**
- **Codes reflected what was in the documentation**

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Clinical Data

Today in AHLTA . . .

- **There are rules for the ordering of diagnoses**
  - **What must be first, what must be one of the first 4, etc**
- **Providers are limited on what they can directly call something**
  - **They aren't limited to the ICD-9 text for what is printed**
  - **What's available isn't as robust as options with written notes**
- **Providers are told that their documentation is wrong**
  - **They are told their code is wrong, but the code *is* the documentation**

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Observation #3

Providers aren’t willing to spend a lot of time looking for the “right” term

Scenario #1

Scenario #1: An 8 month old child is seen today because the doctor saw fluid in the middle ear a month ago and wanted to make sure it cleared after an infection. On exam today there is no fluid seen.

—

Paper chart: Assessment – s/p OM c effusion, now resolved. F/U at WCC in 1 month or PRN.

Scenario #1 (cont)

AHLTA Note:

1. Otitis Media

Comments: Effusion has resolved

1. Visit for: Follow-up Exam

Comments: s/p om w effusion, resolved

Added Frustration: The provider gets a different list of codes depending on if they search for “followup”, “follow up” or “follow-up”

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Scenario #2

A 22 year old type 1 diabetic is 16 weeks pregnant and is coming in for a routine pre-natal visit. During the visit she complains of discharge and a GC probe is collected. It comes back from the lab positive for a Sexually Transmitted Disease.

- **What do the coding rules say needs to be coded?**
- **What would the provider have written in the paper world?**
- **What is the incentive for the providers to do the extra work required to code above and beyond their documentation needs?**

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Clinical Data – ICD-10

AHLTA is undergoing several different changes for ICD-10

- **ICD-10 codes**
- **Multi-Year code sets**

- **AHLTA doesn’t store ICD-9 codes; it stores Medcin codes**
- **A Medcin code maps to a single ICD-9 code . . .**

but it can map to many ICD-10 codes

If providers can’t get coding right today, what are the odds that they’ll get the more specific coding right with ICD-10?

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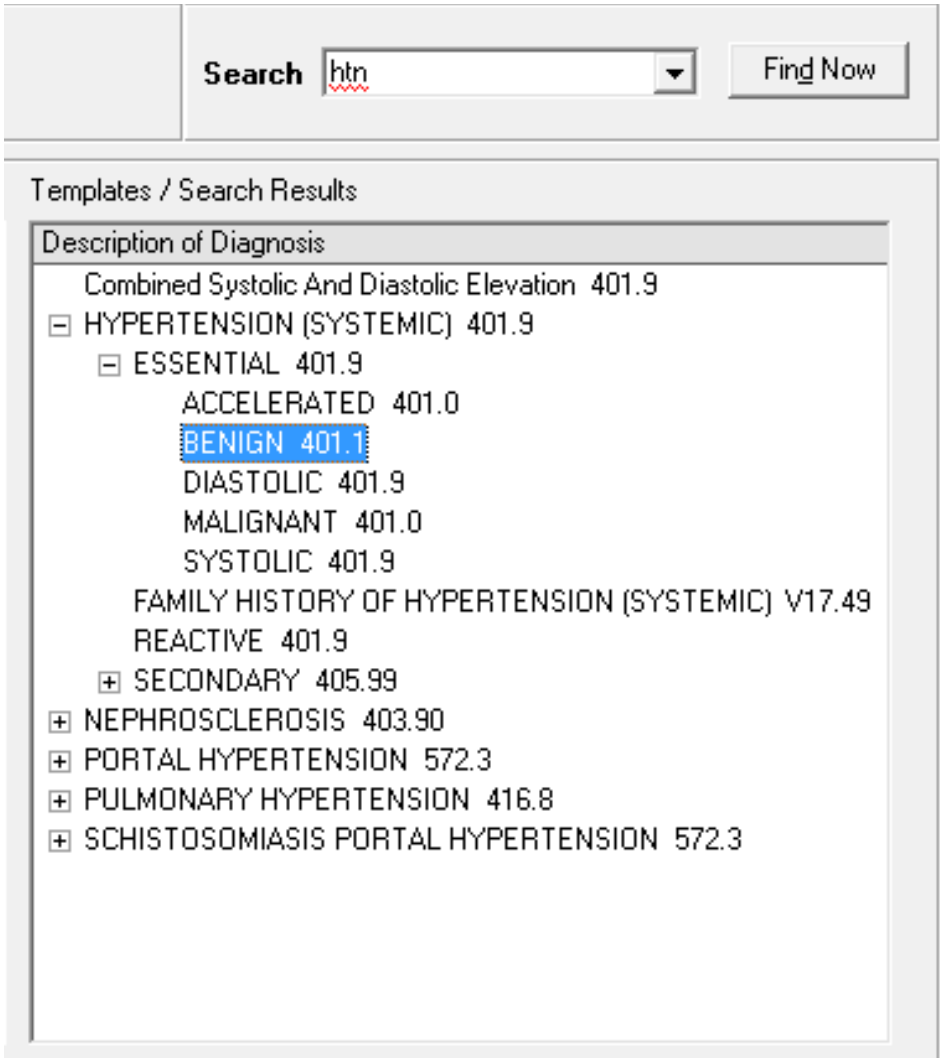
ICD-10 (cont)

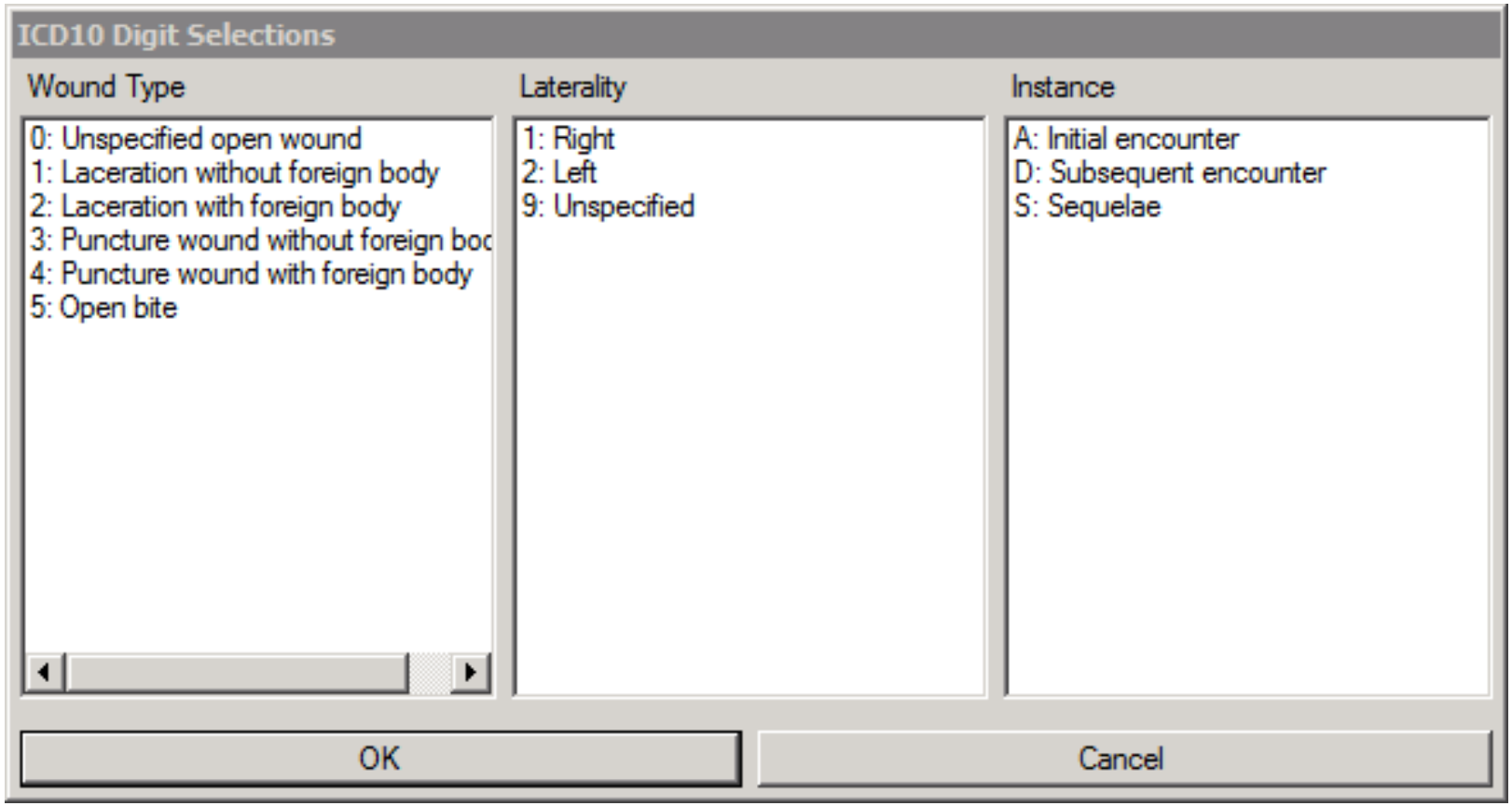
Current state of AHLTA

(ICD-9 code selection)



ICD-10 (cont)

- **Medicomp example for entering additional specificity**



BUSINESS DATA

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Business Data

- There are three categories of codes that providers consider to be “business data”
  - ICD-9/10 codes (discussed previously)
  - CPT/HCPCS codes
  - E&M Codes

In the provider’s eyes, anything else (e.g. MEPRS) is a very distant fourth

Business Data

Procedure (or CPT) Codes in AHLTA

- **Picked from Medcin terms, with a “many to one” mapping to CPT codes**
  - **E.g. both “Electrocardiogram” and “ECG 12-lead with interpretation and report” map to code 93000**
- **The CPT code may or may or may not end up on the final note (new)**
- **Providers *can* search for exact CPT codes if known**
- **Nearly all providers use templates or favorites lists to store their commonly used ones**

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Business Data

“Providers aren’t willing to spend a lot of time looking for the right term”

- **Providers will use what they can easily find, so once a code is in a template it is much more likely to be commonly used, *even if it’s the wrong code!***

- **Work with the AHLTA training staff at your facility to help providers “clean up” the codes they shouldn’t be using out of their templates & favorites lists**

Business Data

HCPCS Codes

- **Observation #1 - “Metrics drive behavior”**
- **If there are no RVUs associated with a code, providers will not be *internally* motivated to capture it**

Business Data

Evaluation & Management Codes

- **See “Observation #1”**
- **They would rather error on the side of “too high” than “too low”**
- **They pick the code they think is “right”**
  - **Especially if they have a lot of free text**

- **Providers are much more likely to be praised for high RVUs than they are to be penalized for inaccurate coding (this also affects CPT coding)**

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Some Final Thoughts

- **"Metrics Drive Behavior"**
  - **If a clinic looks at metrics for RVU generation (and trust me, they do) but they don't care about (or even see) metrics on coding accuracy, it is unlikely that you will get providers to change current coding habits.**

- **"Providers aren't willing to spend a lot of time looking for the 'right' term"**
  - **When looking at either clinical or business data, don't expect a lot of specificity in the coded data. Providers want to finish their note, and if they can't find something quickly they'll pick anything and move on.**

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Some Final Thoughts (cont)

- **“Provider care considerably more about the quality of their documentation than they do about the codes generated”**
  - **Proper training can help enable providers to generate quality notes that still provide the structured data needed by analysts at all levels.**